Janssen CarePath

Initiating benefits investigation is easy

For prescribers

- ☐ Complete the required Prescriber Information and Clinical Information sections on pages 2–3
- ☐ Complete the required Treatment Location Information section on page 4
- ☐ If prior authorization assistance is NOT needed, check the appropriate box in the Prior Authorization section on page 2 to opt out

For your patients/caregivers

- ☐ Complete or have your patient complete the Patient Information and Insurance Information sections on page 1
- ☐ As requested by your patient, complete or have your patient complete the Janssen CarePath Savings Program section on page 2 to determine eligibility
- ☐ If you do not have a signed Business Associate Agreement (BAA) on file with Janssen CarePath, have your patient read, sign, and date the Patient Authorization on pages 5–6
  - Give your patient a copy of the signed Patient Authorization form and keep the original for your records

Fax the completed and signed Benefits Investigation Form to Janssen CarePath at 855-998-4422

You can also request benefits investigations on the Provider Portal at JanssenCarePathPortal.com

Here's what happens next

For prescribers

Janssen CarePath will:

- Confirm receipt of requests within 2 hours and verify benefits within 1 to 2 business days
- Provide you with a verification of benefits and call your patient to review the benefits

For your patients/caregivers

Janssen CarePath will:

- Call your patient to review the benefits and provide you with a verification of benefits
- Inform your patient about cost support options and offer your patient care coordination support services with the infusion provider or specialty pharmacy
- Enroll your eligible patient with commercial or private health insurance in the Janssen CarePath Savings Program, if requested by your patient

DARZALEX® (daratumumab) injection for intravenous infusion 100 mg/5 mL, 400 mg/20 mL

DARZALEX Faspro® (daratumumab and hyaluronidase-fihj) Injection for subcutaneous use | 1,800mg/30,000units

RYBREVANT® (amivantamab-vmjw) Injection for IV Use | 350 mg/7 mL (50 mg/mL)

TALVEY® (talquetamab-tgvs) Injection for subcutaneous use 2 mg/mL and 40 mg/mL

TECVAYLI® (teclistamab-cqyv) Injection for subcutaneous use 10 mg/mL and 90 mg/mL

Yondelis® (trabectedin)

Need help? Call **877-CarePath** (877-227-3728), Monday–Friday, 8:00 AM–8:00 PM ET. Multilingual phone support available

Please read full Prescribing Information for DARZALEX®, DARZALEX *FASPRO*®, RYBREVANT®, and YONDELIS®.

Please read full Prescribing Information, including Boxed Warning, and Medication Guides for TALVEY® and TECVAYLI®. Provide the Medication Guide to your patients and encourage discussion.

YONDELIS® (trabectedin) is under license from Pharma Mar, S.A.

Janssen CarePath UPDATE 03.24

Medical Benefits Investigation Form

Janssen CarePath cannot accept any information without an executed Business Associate Agreement or Patient Authorization Form, which can be found at JanssenCarePath.com or as the last 2 pages of this document. The information you provide will be used by Janssen Biotech, Inc., our affiliates, and our service providers for your patient's enrollment and participation in Janssen CarePath. Our Privacy Policy governs the use of the information you provide. By submitting this form, you indicate that you read, understand, and agree to these terms.

1. Patient Information (Required)

First Name _____ MI _____ Last Name _____ Language ☐ English ☐ Spanish

☐ Male ☐ Female Date of Birth (mm/dd/yyyy) _____

Address _____

City _____ State _____ ZIP _____

Primary Email _____ Secondary Email (Optional) _____

Primary Phone _____ Secondary Phone (Optional) _____ Best Time to Contact _____

Caregiver/Contact _____
(A caregiver/contact is someone who can be contacted in place of the patient)

Phone _____ Best Time to Contact _____

☐ I authorize Janssen CarePath to leave a message, including the name of the Janssen medication indicated on this form, if I am unavailable when they call.

☐ If I cannot be reached, I authorize Janssen CarePath to contact my caregiver.

☐ I prefer and authorize Janssen CarePath to contact my caregiver in place of me.

2. Medical Insurance Information (Required)

Please provide insurance information for all health insurance coverage you may have.

☐ **Please see attached front and back copy of insurance card.**

Primary Medical Insurance (Required)

Primary Insurance Carrier _____ Phone _____

Cardholder Name (First, MI, Last) _____ Relationship to Cardholder _____

Policy # _____ Group # ergehraherha

Secondary Medical Insurance (Optional)

Secondary Insurance Carrier _____ Phone _____

Cardholder Name (First, MI, Last) _____ Relationship to Cardholder _____

Policy # _____ Group # _____

☐ **Please investigate out-of-network benefits.**

Information about your patient's insurance coverage, cost support options, and treatment support is given by service providers for Janssen CarePath. The information you get does not require you or your patient to use any Janssen product. Because the information we give you comes from outside sources, Janssen CarePath cannot promise the information will be complete. Janssen CarePath cost support is not for patients in the Johnson & Johnson Patient Assistance Foundation.

Janssen CarePath

Medical Benefits Investigation Form

3. Janssen CarePath Savings Program (Optional)

Eligible patients using commercial insurance can save on out-of-pocket Janssen medication costs. See program requirements at JanssenCarePath.com.

☐ I would like Janssen CarePath to check the patient's eligibility for and enroll the patient into the Janssen CarePath Savings Program if the results of this benefits investigation determine that the patient has commercial or private health insurance.

4. *Janssen Compass*® (Optional)

All eligible patients will be contacted by a Care Navigator through the *Janssen Compass*® program.*

Janssen Compass® is a free, personalized patient support program that offers patients access to a dedicated Care Navigator who will provide one-on-one guidance over the phone. See terms and conditions at **JanssenCompass.com/signup**. A Care Navigator will contact the patient within 1 business day unless you select the check box below to opt your patient out. If you would like to speak with a Care Navigator immediately, please call 844-628-1234, Monday–Friday, 8:30 AM–8:30 PM ET.

☐ I would **NOT** like my patient to be contacted by a Care Navigator to learn how *Janssen Compass*® may be able to provide additional education and support.

**Janssen Compass*® is limited to education for patients about their Janssen therapy, its administration, and/or their disease. It is intended to supplement a patient's understanding of their therapy and is not intended to provide medical advice, replace a treatment plan from the patient's doctor or nurse, provide case management services, or serve as a reason to prescribe a Janssen medication.

5. Prescriber Information—to be completed by Physician (Required)

First Name _____ Last Name _____ Specialty _____

Practice Name _____ Office Contact Name _____

Address _____

City _____ State _____ ZIP _____

Email _____ Office Contact Phone _____ Fax _____

Medicaid/Medicare Provider # _____ Tax ID # _____

State License # _____ UPIN/NPI # _____ ICD-10 Diagnosis Code(s): _____

6. Prior Authorization—to be completed by Physician (Optional)

Automatically provided with benefits investigation. You may opt out by checking the box below.

Prior Authorization Form Assistance and Status Monitoring: Janssen CarePath assists your office in providing the requirements of the patient's health plan related to prior authorization for treatment with the medication specified on this form. Assistance includes obtaining the health-plan-specific prior authorization form and providing it based upon the patient-specific information provided on this form. The partially completed prior authorization form, if received from the health plan, will be provided to your office for possible completion and submission in the office's sole discretion. Janssen CarePath also actively monitors the status of prior authorization submission to the patient's plan and provides status updates to your office with respect to this patient's prior authorization for treatment with the medication specified on this form.

☐ I do **NOT** wish to receive Prior Authorization Form Assistance or Status Monitoring.

Janssen CarePath

Medical Benefits Investigation Form

7. Clinical Information for Benefits Investigation—to be completed by Physician (Required)

Medication

- ☐ DARZALEX® (daratumumab)
- ☐ DARZALEX *FASPRO*® (daratumumab and hyaluronidase-fihj)
- ☐ RYBREVANT® (amivantamab-vmjw)
- ☐ TALVEY® (talquetamab-tgvs)
- ☐ TECVAYLI® (teclistamab-cqyv)
- ☐ YONDELIS® (trabectedin)

Treatment Information (If prescribing TALVEY® or TECVAYLI®, skip to section below)

Dosage Form and Strength _____ No. of Vials _____

Administration _____

Patient Weight _____ lb _____ kg

Has the patient started therapy with the medication specified above? ☐ Yes ☐ No

If yes, what date did the patient start therapy? (mm/dd/yyyy) _____

Additional information regarding treatment (if applicable to benefits verification) _____

DARZALEX® and DARZALEX *FASPRO*® only:

- ☐ Monotherapy
- ☐ Combination Therapy

If Combination, list medications:

_____

_____

Prior Medications/Treatments:

_____

_____

RYBREVANT® only:

Is the patient Exon 20 positive? ☐Yes ☐No

Is the patient currently on or have they previously taken a platinum-based chemotherapy? ☐Yes ☐No

If yes, list which platinum-based chemotherapy:

_____

_____

YONDELIS® only:

Has the patient taken a prior chemotherapy?
☐Yes ☐No

If yes, what prior chemotherapy has the patient taken?

- ☐ Anthracycline
- ☐ Ifosfamide
- ☐ Other _____

TALVEY® only:

Patient Weight _____ lb _____ kg

Has the patient received at least four prior lines of therapy, including a proteasome inhibitor, an immunomodulatory agent, and an anti-CD38 monoclonal antibody? ☐Yes ☐No

Weekly Dosing:

- ☐ **Step-Up Dosing**
  - ☐ Step-Up Dose 1 (0.01 mg/kg): 3 mg/1.5 mL single-dose vial
  - ☐ Step-Up Dose 2 (0.06 mg/kg): 3 mg/1.5 mL single-dose vial
    No. of Vials _____
  - ☐ First Treatment Dose (0.4 mg/kg): 40 mg/mL single-dose vial
    No. of Vials _____
- ☐ **Weekly Dosing**
  - ☐ Subsequent Treatment Doses (0.4 mg/kg): 40 mg/mL single-dose vial
    No. of Vials _____

Biweekly (Every 2 Weeks) Dosing:

- ☐ **Step-Up Dosing**
  - ☐ Step-Up Dose 1 (0.01 mg/kg): 3 mg/1.5 mL single-dose vial
  - ☐ Step-Up Dose 2 (0.06 mg/kg): 3 mg/1.5 mL single-dose vial
    No. of Vials _____
  - ☐ Step-Up Dose 3 (0.4 mg/kg): 40 mg/mL single-dose vial
    No. of Vials _____
  - ☐ First Treatment Dose (0.8 mg/kg): 40 mg/mL single-dose vial
    No. of Vials _____
- ☐ **Biweekly (Every 2 Weeks) Dosing**
  - ☐ Subsequent Treatment Doses (0.8 mg/kg): 40 mg/mL single-dose vial
    No. of Vials _____

TECVAYLI® only:

Patient Weight _____ lb _____ kg

Has the patient received at least four prior lines of therapy, including a proteasome inhibitor, an immunomodulatory agent, and an anti-CD38 monoclonal antibody? ☐Yes ☐No

Recommended Dosing:

- ☐ **Step-Up Dosing**
  - ☐ Step-Up Dose 1 (0.06 mg/kg): 30 mg/3 mL (10 mg/mL) single-dose vial
  - ☐ Step-Up Dose 2 (0.3 mg/kg): 30 mg/3 mL (10 mg/mL) single-dose vial
    No. of Vials _____
  - ☐ First Treatment Dose (1.5 mg/kg): 153 mg/1.7 mL (90 mg/mL) single-dose vial
    No. of Vials _____
- ☐ **Weekly Dosing**
  - ☐ Subsequent Treatment Doses (1.5 mg/kg): 153 mg/1.7 mL (90 mg/mL) single-dose vial
    No. of Vials _____

While receiving TECVAYLI®, has the patient achieved and maintained a complete response or better for a minimum of 6 months?
☐Yes ☐No

If yes, the following dosing frequency decrease may be considered

- ☐ **Biweekly (Every 2 Weeks) Dosing**
  - ☐ Subsequent Treatment Doses (1.5 mg/kg): 153 mg/1.7 mL (90 mg/mL) single-dose vial
    No. of Vials _____

Please read full Prescribing Information for DARZALEX®, DARZALEX *FASPRO*®, RYBREVANT®, and YONDELIS®.

Please read full Prescribing Information, including Boxed Warning, and Medication Guides for TALVEY® and TECVAYLI®. Provide the Medication Guide to your patients and encourage discussion.

Janssen CarePath

Medical Benefits Investigation Form

8a. Treatment Location Information—to be completed by Physician (Required)

Dosage Type (Required for TALVEY® [talquetamab-tgvs] and TECVAYLI® [teclistamab-cqyv] only)

☐ Step-Up Phase ☐ Treatment Phase

Treatment Location Type (If additional treatment location is needed, please complete section 8b below)

☐ Prescribing MD's Office ☐ Non-prescribing MD's Office ☐ Home Infusion/Infusion Provider Company
☐ Hospital Outpatient ☐ Hospital Inpatient ☐ Other _____

Provider Information

If prescribing MD's office, the fields below do not need to be completed if information is the same as the Prescriber Information section.

Provider First Name _____ Provider Last Name _____ Physician Specialty _____

Practice Name _____

Address _____

City _____ State _____ ZIP _____

Site Phone _____ Site Fax _____

Insurance Provider # _____ Tax ID # _____

8b. Additional Treatment Location Information—to be completed by Physician (Required for TALVEY® and TECVAYLI® if patient will be treated at more than one location)

Dosage Type (Required)

☐ Step-Up Phase ☐ Treatment Phase

Treatment Location Type

☐ Prescribing MD's Office ☐ Non-prescribing MD's Office ☐ Home Infusion/Infusion Provider Company
☐ Hospital Outpatient ☐ Hospital Inpatient ☐ Other _____

Provider Information

If prescribing MD's office, the fields below do not need to be completed if information is the same as the Prescriber Information section.

Provider First Name _____ Provider Last Name _____ Physician Specialty _____

Practice Name _____

Address _____

City _____ State _____ ZIP _____

Site Phone _____ Site Fax _____

Insurance Provider # _____ Tax ID # _____

Please read full Prescribing Information, including Boxed Warning, and Medication Guides for TALVEY® and TECVAYLI®. Provide the Medication Guide to your patients and encourage discussion.

Janssen Patient Support Program
Patient Authorization Form

- **Patients should read the Patient Authorization, check the desired permission boxes, and return both pages of the Form to the Janssen Patient Support Program**
  - **Download a copy, print, check the desired boxes, and sign. Your healthcare provider may scan the completed Form and upload on Provider Portal, or completed Form may be faxed to 855-998-4422 or mailed to Janssen CarePath, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560**
  - **You may be able to eSign a digital Form in your healthcare provider's office or on the Janssen CarePath Patient Account at MyJanssenCarePath.com**

Patient Name: _____ **Email Address:** _____

I give permission for each of my "Healthcare Providers" (eg, my physicians, pharmacists, specialty pharmacies, other healthcare providers, and their staff) and "Insurers" (eg, my health insurance plans) to share my Protected Health Information as described on this Form.

My "Protected Health Information" includes any and all information related to my medical condition, treatment, prescriptions, and health insurance coverage.

The following person(s) or class of person(s) are given permission to receive and use my Protected Health Information (collectively "Janssen"):

- Johnson & Johnson Health Care Systems Inc., its affiliated companies, agents, and representatives
- Providers of other sources of funding, including foundations and co-pay assistance providers
- Service providers for the patient support programs, including subcontractors or Healthcare Providers helping Janssen run the programs
- Service providers maintaining, transmitting, de-identifying, aggregating, or analyzing data from Janssen patient support programs

Also, I give permission to Janssen to receive, use, and share my Protected Health Information in order to:

- see if I qualify for, sign me up for, contact me about, and provide services relating to Janssen patient support programs, including in-home services
- manage the Janssen patient support programs
- give me educational and adherence materials, information, and resources related to my Janssen medication in connection with Janssen patient support programs
- communicate with my Healthcare Providers regarding access to, reimbursement for and fulfillment of my Janssen medication, and to tell my Healthcare Provider that I am participating in Janssen patient support programs
- verify, assist with, and coordinate my coverage for my Janssen medication with my Insurers and Healthcare Providers
- coordinate prescription or treatment location and associated scheduling
- conduct analysis to help Janssen evaluate, create, and improve its products, services, and customer support for patients prescribed Janssen medications
- share and give access to information created by the Janssen patient support programs that may be useful for my care

I understand that my Protected Health Information may be shared by Janssen for the uses written in this Form to:

- My Insurers
- My Healthcare Providers
- Any of the persons given permission to receive and use my Protected Health Information as mentioned above
- Any individual I give permission as an additional contact

Janssen Patient Support Program
Patient Authorization Form

Janssen and the other data recipients listed on this Form may share information about me as permitted on this Form or if any information that specifically identifies me is removed. I understand that Janssen will use reasonable efforts to keep my information private but once my Protected Health Information is disclosed as allowed on this Form, it may no longer be protected by federal privacy laws.

I understand that I am not required to sign this Form. My choice about whether to sign will not change how my Healthcare Providers or Insurers treat me. If I do not sign this Form, or cancel or remove my permission later, I understand I will not be able to participate or receive assistance from Janssen's patient support programs.

I understand that pharmacies that dispense and ship my medication and service providers for the patient support programs may be paid by Janssen for their services and data. This may include payment for sharing Protected Health Information and other data in connection with these programs, as allowed on this Form.

This Form will remain in effect 10 years from the date of signature, except where state law requires a shorter time, or until I am no longer participating in any Janssen patient support programs. Information collected before that date may continue to be used for the purposes set forth in this Form.

I understand that I may cancel the permissions given by this Form at any time by letting Janssen know in writing at: Janssen CarePath, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560

I can also cancel my permission by letting my Healthcare Providers and Insurers know in writing that I do not want them to share any information with Janssen.

I further understand that if I cancel my permission it will not affect how Janssen uses and shares my Protected Health Information received by Janssen prior to my cancellation.

I understand I may request a copy of this Form.

Permission for communications outside of Janssen patient support programs:

☐ Yes, I would like to receive communications relating to my Janssen medication.

☐ Yes, I would like to receive communications relating to other Janssen products and services.

For privacy rights and choices specific to California residents, please see Janssen's California privacy notice available at **https://www.janssen.com/us/privacy-policy#california**

Permission for text communications:

☐ Yes, I would like to receive text messages. By selecting this option, I agree to receive text messages as allowed by this Form to the cell phone number provided below. Message and data rates may apply. Message frequency varies. I understand I am not required to provide my permission to receive text messages to participate in the Janssen patient support programs or to receive any other communications I have selected.

Cell phone number: _____

Patient name (print): _____

Patient sign here: _____ **Date:** _____

If the patient cannot sign, patient's legally authorized representative must sign below:

By: _____ **Print Name:** _____ **Date:** _____

(Signature of person legally authorized to sign for patient)

Describe relationship to patient and authority to make medical decisions for patient:

_____